STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-ALLEGHANY	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 12/13/16 through 12/15/16. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities. The census in this 105 certified bed facility was 101 at the time of the survey. The survey sample consisted of eighteen current resident reviews (Residents 1 through 18) and three closed record reviews (Residents 19 through 21).	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: Nursing Services 12 VAC5-371-220 A - Cross reference to F323 12VAC5-371-220 B - Cross reference to F309 Pharmaceutical Services 12VAC5-371-300 A, B - Cross reference to F431 Diagnostic Services 12VAC5-371-310 A - Cross reference to F502 Maintenance and Housekeeping 12VAC5-371-370 A - Cross reference to F460, F465	F 001	This plan of correction is the facility's credible allegation of compliance. **F001** **Nursing Services** **12 VAC5-371-220 A – Cross Reference to F323** **12 VAC5-371-220B – Cross Reference to F309** **Pharmaceutical Services** **12 VAC5-371-300 A, B – Cross Reference to F431** **Diagnostic Services** **12 VAC5-371-310 A – Cross Reference to F502** **Maintenance and Housekeeping** **12 VAC5-371-370A – Cross Reference to F460, F465**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 12/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/13/16 through 12/15/16. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 105 certified bed facility was 101 at the time of the survey. The survey sample consisted of eighteen current resident reviews (Residents 1 through 18) and three closed record reviews (Residents 19 through 21).	F 000		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309	**F 309** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #9 and #13 were assessed for pain and the use of non-pharma logical interventions by 12/23/16 and Resident #16 on date of error, again the following day by nurse manager and on 12/11/16 by the Nurse Unit Managers. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents with prn pain medication orders have the potential to be affected. EMAR's will be assessed for prn narcotic use for potential of deficient practice. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Nurse Unit Managers will assess/review residents with current prn narcotic medication orders and non-pharma logical interventions. Nurses will be re-educated and re-in serviced by the Nurse Director of Clinical Education or RN Unit Manager on the 5 rights of medication administration, use of non-pharma logical interventions prior to administration of prn narcotic medications and documentation on location and severity of pain. Nurses will utilize a non-pharma logical care plan individualized for residents with prn narcotic medication prior to administration of prn narcotic medication. These will be located on each unit in documentation book.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Theresa D. Sedore	Administrator	12/22/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1	F 309	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Nurse Unit Managers will review the non –pharma logical care plan for prn narcotic medications in daily clinical stand up meetings. Care plans will be analyzed and discussed at the facility QAPI meeting monthly for 3 months for discussion, analysis and recommendations. **5.) Date Corrective Action will be completed.** Compliance Date is 01/04/17	

of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, resident interview and clinical record review, the facility staff failed to follow physician orders for two of 21 residents in the survey sample (Resident #9 and #16) and administered as needed pain medications without a documented pain assessment or prior attempts of non-drug interventions for two of 21 residents (Resident #9 and #13).

Resident #9 was administered Hydromorphone for pain rated as 7, 8 and 9 when the physician ordered the medication to be administered for pain rated 1 through 5. In addition, Resident #9 was administered six as needed doses of the medication Percocet and two as needed doses of Hydromorphone from 12/1/16 through 12/12/16 with no documented assessment indicating the location of the pain or of any prior attempts of non-drug interventions.

Resident #13 was administered thirteen as needed doses of the medication Ultram without a documented assessment of the pain or prior attempts of non-drug interventions.

Resident #16 was administered a dose of the medication Methadone instead of physician ordered Dilaudid.

The findings include:

1a. Resident #9 was administered Hydromorphone (Dilaudid) for pain rated as 7, 8 and 9 when the physician ordered the medication

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to be administered for pain rated 1 through 5.

Resident #9 was admitted to the facility on 4/27/16 with diagnoses that included Guillian-Barre syndrome, diabetes, neuropathy and depression. The minimum data set (MDS) dated 10/20/16 assessed Resident #9 as cognitively intact.

Resident #9's clinical record documented a physician's order dated 10/4/16 for the medication Hydromorphone 2 mg (milligrams) to be administered every 3 hours as needed for pain rated 1 through 5 (on scale of 1 to 10 with 1 as least pain and 10 as worst pain). The record also documented a physician's order dated 10/10/16 for Percocet 5-325 mg to be administered every 3 hours as needed for pain rated 2 through 9.

The resident's medication administration record (MAR) for December 2016 documented the resident was administered Hydromorphone on 12/1/16 with a pain rated as 7; on 12/3/16 with pain rated as 8 and on 12/12/16 with pain rated as 9. The MAR notes and nursing notes documented no rationale for why the Hydromorphone was administered with pain scale ratings of 7, 8, and 9.

On 12/14/16 at 9:45 a.m. the licensed practical nurse (LPN #1) unit manager was interviewed about the Hydromorphone administered to Resident #9 with pain rated as 7, 8 and 9. LPN #1 stated she did not know why the Hydromorphone was administered because the resident had an order for Percocet to be administered for pain rated 2 through 9. On 12/15/16 at 7:40 a.m. LPN #1 stated she was unable to reach the nurse that administered the

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Hydromorphone and had no further information about why the order was not followed.

These findings were reviewed with the administrator and director of nursing during a meeting on 12/14/16 at 3:30 p.m.

1b. Resident #9 was administered six as needed doses of the medication Percocet and two as needed doses of Hydromorphone from 12/1/16 through 12/12/16 with no documented assessment indicating the location of the pain or of any prior attempts of non-drug interventions.

Resident #9's clinical record documented a physician's order dated 10/4/16 for the medication Hydromorphone 2 mg (milligrams) to be administered every 3 hours as needed for pain rated 1 through 5. The record also documented a physician's order dated 10/10/16 for Percocet 5-325 mg to be administered every 3 hours as needed for pain rated 2 through 9.

Resident #9's medication administration record (MAR) for December 2016 documented six as needed doses of Percocet and two doses of Hydromorphone were administered to Resident #6. Percocet was administered on 12/1/16 (2 doses), 12/3/16, 12/15/16, 12/9/16 and 12/11/16. Hydromorphone was administered on 12/3/16 and 12/12/16. The clinical record including MAR notes documented no location, description or any assessment of the resident's pain associated with the administration of the Percocet or Hydromorphone other than the pain rating. There were no documented offers or attempts of non-pharmacological interventions to alleviate or reduce pain.

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Resident #9's plan of care (revised 10/26/16) listed the resident experienced pain and his pain was worse with movement. The care plan documented the resident required pain management due to neuropathy and muscle spasms. Interventions to reduce and/or alleviate pain included medications as ordered, dim light/quiet environment, music, spiritual support, pain evaluation tool, prayer/meditation and rest. Care plan interventions also stated, "...Evaluate characteristics and frequency/pattern of pain...Evaluate need to provide medications prior to treatment or therapy...Evaluate what makes the patient's pain worse... Utilize pain monitoring tool to evaluate effectiveness of interventions..."

On 12/14/16 at 9:45 a.m. the licensed practical nurse (LPN #1) unit manager was interviewed about the lack of pain assessment when the as needed medications were administered to Resident #9. LPN #1 stated the computerized medication system required entry of a pain rating scale at the time of administration. LPN #1 stated nurses were supposed to add a note in the system documenting the location, description and any interventions implemented in addition to the pain rating. On 12/15/16 at 7:40 a.m. LPN #1 was interviewed again about any pain assessments for Resident #9. LPN #1 stated she was unable to reach the nurse that gave the pain medications and had no further information about the assessments associated with the administration of the pain medications.

These findings were reviewed with the administrator and director of nursing during a meeting on 12/14/16 at 3:30 p.m.

The Drug Information Handbook for Nursing 13th

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edition on page 608 describes Hydromorphone as an opioid analgesic used for the management of moderate to severe pain and states, "The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have a heightened risk of causing significant patient harm when used in error." Page 609 of this reference states, "An opioid-containing analgesic regimen should be tailored to each patient's needs and based upon the type of pain being treated (acute versus chronic)... The optimal analgesic dose varies widely among patients. Doses should be titrated to pain relief/prevention." (1)

The Drug Information Handbook for Nursing 13th edition on page 914 describes Percocet (oxycodone and acetaminophen) as an opioid analgesic used for the management of moderate to severe pain and states, "The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have a heightened risk of causing significant patient harm when used in error." (1)

2. Resident #13 was administered thirteen as needed doses of the medication Ultram without a documented assessment of the pain or of any attempted non-drug interventions.

Resident #13 was admitted to the facility on 7/14/16 with diagnoses that included bipolar disorder, anxiety disorder, depression, delusional disorder and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 10/17/16 assessed Resident #13 as cognitively intact.

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Resident #13's clinical record documented a physician's order dated 7/17/16 for the medication Ultram 50 mg (milligrams) to be administered every 6 hours as needed for pain. The resident's medication administration record (MAR) for December 2016 documented thirteen doses of Ultram administered for pain rated from 2 to 7 on a scale of 1 to 10 (1 as least pain and 10 as worst pain). Ultram was administered to Resident #13 on 12/1/16, 12/3/16 (2 doses), 12/4/16, 12/5/16, 12/8/16, 12/9/16 (2 doses), 12/10/16, 12/11/16, 12/12/16 (2 doses) and 12/13/16. The clinical record including MAR notes documented no location, description or any assessment of the resident's pain associated with the administration of the Ultram other than the pain rating. There were no documented offers or attempts of non-pharmacological interventions to alleviate or reduce the resident's pain.

Resident #13's plan of care (revised 10/24/16) listed the resident required pain management and monitoring due to generalized pain. Care plan interventions to reduce pain included dim light/quiet environment, evaluate what makes pain worse, medications as ordered, music, pet therapy, prayer/meditation, repositioning and rest.

On 12/14/16 at 7:45 a.m. the registered nurse (RN #1) caring for Resident #13 was interviewed about any pain assessments or non-drug interventions associated with the administration of the Ultram. RN #1 stated Resident #9 frequently complained of pain "all over" and in her back and legs. RN #1 stated they have tried diversional activities and redirection with the resident to improve pain. RN #1 stated the MAR provided a place for the pain rating and there was a place to add notes as needed. RN #1 stated the location

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and description of the resident's pain should have been documented when the pain medications were administered.

On 12/14/16 at 7:55 a.m. the licensed practical nurse (LPN #1) unit manager was interviewed about Resident #9's pain assessments and interventions. LPN #1 stated Resident #9 asked for the Ultram almost daily. LPN #1 stated they had tried activities and redirection but the resident was always anxious and "very nervous." LPN #1 stated the resident usually asked for the Ultram for "pain all over." LPN #1 stated nurses should be recording the location and description of the resident's pain in addition to any offered activities or diversions.

The Drug Information Handbook for Nursing 13th edition on pages 1191 and 1192 describes Ultram (Tramadol) as an opioid analgesic used for the relief of moderate to moderately-severe pain and states Ultram may cause flushing, dizziness and insomnia. (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 12/14/16 at 11:30 a.m.

3. Resident #16 was administered a dose of the medication Methadone instead of physician ordered Dilaudid.

Resident #16 was admitted to the facility on 8/6/15 with a re-admission on 11/22/16. Diagnoses for Resident #16 included multiple sclerosis, anxiety and respiratory failure. The minimum data set (MDS) dated 12/6/16 assessed Resident #16 as cognitively intact.

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Resident #16's clinical record documented a physician's order dated 11/29/16 for the medication Dilaudid 8 mg (milligrams) to be administered every 6 hours for chronic pain. The record also documented a physician's order dated 11/22/16 for Methadone 10 mg to be administered three times per day.

Resident #16's medication administration record (MAR) for December 2016 documented the Dilaudid dose scheduled for 12/11/16 at 12:00 a.m. was not administered as ordered. A nursing note dated 12/11/16 at 1:00 a.m. documented, "Accidentally gave resident methadone instead of dilaudid at midnight... Denies any side effects from med [medication] mixup... Notified MD...Dilaudid Tablet 8 mg...Held per MD...Resident received methadone."

On 12/14/16 at 1:45 p.m. Resident #16 was interviewed about the medication error on 12/11/16. Resident #16 stated she was informed about the mix up of the Methadone and Dilaudid and she had no problems from the error. Resident #16 stated she had taken both medications for a "long time" and had a tolerance for the medications.

On 12/14/16 at 1:50 p.m. the licensed practical nurse (LPN #1) unit manager was interviewed about the medication error on 12/11/16. LPN #1 stated the night nurse "pulled the wrong med [medication]." LPN #1 stated the nurse realized the error and reported it. LPN #1 stated she talked with the nurse that made the error and the nurse stated she pulled the methadone by mistake and she thought she was giving the Dilaudid.

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These findings were reviewed with the administrator and director of nursing during a meeting on 12/14/16 at 3:30 p.m.

The Drug Information Handbook for Nursing 13th edition on page 780 describes Methadone as an opioid analgesic used for the management of moderate to severe pain and states, "The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have a heightened risk of causing significant patient harm when used in error." This reference states Methadone has a "U.S. Black Boxed Warning: May cause respiratory depression. Use caution in patients with respiratory disease or pre-existing respiratory conditions..." (1)

The Drug Information Handbook for Nursing 13th edition on page 608 describes Dilaudid as an opioid analgesic used for the management of moderate to severe pain and states, "The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have a heightened risk of causing significant patient harm when used in error." (1)

(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

F 323 SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free

F 323

F 323

1.) How the Corrective Action was accomplished for those residents found to have been affected.

The bed was lowered to the height as indicated on the plan of care on 12/14/16. Nursing staff were verbally reeducated and rein-serviced on resident specific interventions.

2.) How the facility will identify other residents having the potential to be affected by the deficient practice.

Residents with interventions that indicated "bed in low position at all times" had the potential to be affected.

3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

A facility review of residents with fall interventions was conducted by the Nurse Unit Managers to ensure that fall interventions were in place. The Nurse Director of Clinical Education will reeducate and rein-service staff on the use of resident kardex which indicates specific resident fall interventions.

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F 323	Continued From page 10 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to implement safety interventions for one of 21 residents in the survey sample. Resident #6 was in a high positioned bed when her plan of care required a low bed position at all times for fall prevention. The findings include: Resident #6 was admitted to the facility on 12/10/13 with a re-admission on 3/20/14. Diagnoses for Resident #6 included schizophrenia, peripheral vascular disease, diabetes, above knee amputation and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 10/28/16	F 323	**4.) The Facility will monitor its performance to make sure solutions are sustained.** Zone Round audits will be assigned and completed by departmental staff weekly to ensure fall interventions are in place. Audits will be reviewed and discussed and analyzed at our monthly QAPI meetings for 3 months for recommendation and follow up. Ongoing review of residents with falls interventions will be discussed and reviewed in QAPI. **5.) Date Corrective Action will be completed.** Compliance Date is 01/04/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

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F 323	Continued From page 11 assessed Resident #6 with moderately impaired cognitive skills. On 12/14/16 at 7:40 a.m. Resident #6 was observed in bed in her room without any staff members present. The bed height was positioned high, approximately 3 feet from the floor. The resident' left leg was hanging off the side of the bed with her foot not touching the floor. On 12/14/16 at 7:45 a.m. accompanied by registered nurse (RN) #1, Resident #6 was observed in the high bed with her left leg hanging off the side of the mattress. RN #1 was interviewed at this time about the high bed height for Resident #6. RN #1 stated the resident's bed was supposed to be in the low position. RN #1 stated she did not know why the resident was left unattended with the bed in the high position. Resident #6's plan of care (revised 12/2/16) listed the resident was at risk for falls due to her use of medications, impaired mobility and right above knee amputation with no use of a prosthesis. Care plan interventions to prevent falls included, "Bed in low position at all times." These findings were reviewed with the administrator and director of nursing during a meeting on 12/14/16 at 3:30 p.m.	F 323	**F 431** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The facility medication refrigerators were checked for any expired or undated medications, and then they were removed and disposed of per facility protocol by 12/14/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents of the facility with medications requiring refrigeration had the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Nurse Director of Clinical Education or Unit Manager will re-educate and re-in-service the nurses on monitoring medication storage, medication destruction policy and proper labeling of medications. Nurses will be reeducated and rein serviced by 01/04/17. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Audits will be conducted 3 times per week for 3 months by the MDS nurses of the medication refrigerators to ensure compliance. Upon shift change, Charge nurses will ensure medications in medication refrigerators are not expired and will document such on accountability sheets. These findings will be brought through the monthly QAPI meeting for further review and recommendations.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit	F 431		

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F 431	Continued From page 12 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked,	F 431	**5.) Date Corrective Action will be completed.** Compliance Date is 01/04/17	

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F 431	Continued From page 13	F 431		

permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to ensure expired medication was not available for administration.

The facility staff failed to ensure medication (Lorazepam injectable) was not available for administration on one of three nursing wings (C wing).

Findings include:

The C- wing medication room was observed on 12/14/16 at 9:00 a.m. with LPN (Licensed Practical Nurse) # 1.

During the observation, LPN # 1 opened the locked refrigerator, opened the lock box inside of the refrigerator and removed a small plastic bag that contained approximately 8 to 10 unopened vials of Lorazepam (for injection). One of the vials of Lorazepam was expired and had the expiration date of "11/2016" imprinted on the vial.

The LPN was made aware of the one, expired vial of Lorazepam. The LPN stated, "I'll get rid of that." The LPN was asked how often are these medications checked for expiration. The LPN stated that the medications are to be checked

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F 431	Continued From page 14 with each count, at the beginning and end of each shift. The LPN further stated that the pharmacy had recently been in and must have missed it. LPN # 1 was asked for a policy on expired medications. A policy was presented and reviewed. The policy titled, "Storage of Medications" documented, "...Outdated...medications...are immediately removed from inventory, disposed of according to procedures...Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date...When the beyond-use dating for a medication identifies a month and year, the medication can be used through the last day of the month...No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining..." The administrator and DON (director of nursing) were made aware of the above in a meeting with the survey team on 12/14/16 at approximately 11:45 a.m. No further information or documentation was presented prior to the exit conference.	F 431		
F 460 SS=D	483.90(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY (d)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; (d)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend	F 460	**F 460** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** The cubicle curtain in Unit B Room 6 bed 2 was replaced on 12/14/16 **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Rooms with cubicle curtains have the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** No other resident rooms requiring cubicle curtains were found not to be in place. Housekeeping staff was reeducated and rein-serviced by the Director of Housekeeping on 12/15/16 on the process of changing and rehanging privacy curtains. Reeducation and rein-service instructed staff when taking down privacy curtains to immediately replace the curtain.	

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F 460	Continued From page 15 around the bed to provide total visual privacy in combination with adjacent walls and curtains This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure full visual privacy in a Resident's room. Unit "B," room 6, bed 2 (closest to the window) did not have a privacy curtain in place. The Findings Include: General observations were conducted on 12/14/16 beginning at 8:45 a.m. During a tour throughout the facility room B-6 was observed (the room was a two person room). A Resident was sleeping in the 2nd bed and a bedside commode was beside the bed (indicating the Resident uses a bed side commode). The 2nd bed did not have a privacy curtain in place. The above mentioned room was observed again at 9:30 a.m. (12/14/16) and again without a privacy curtain. On 12/16/16 at 9:40 a.m. an interview was conducted with the charge nurse (registered nurse, RN #1) for unit "B." During the interview with RN #1, RN #1 verbalized that the Resident in room B-6 2nd bed uses the bedside commode. When asked about the whereabouts of the privacy curtain, RN #1 (along with this surveyor) went to the room in question and also observed that there was no privacy curtain. RN #1 verbalized there is no reason that there should not be a privacy curtain, but did verbalized that there had been a recent outbreak of scabies	F 460	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The Housekeeping Manager will complete an audit weekly for three months of rooms requiring cubicle curtains for compliance with privacy. The audit will be submitted to the Administrator for review. The Administrator will present a summary of the audits in QAPI for discussion, findings and action steps. **5.) Date Corrective Action will be completed.** Compliance Date is 01/04/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

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F 460	Continued From page 16 and all linens were washed and treated and putting the privacy curtain back in place could have been missed. On 12/14/16 at 10:00 a.m. the house keeping supervisor (other staff, OS #1) was asked to observe the room without a privacy curtain. OS #1 observed the Residents room and verbalized that there should be a privacy curtain in place and verbalized that she would replace the curtain. On 12/14/16 at 11:30 a.m. during a meeting with the administrator and the director of nursing (DON) the above information was presented, the DON verbalized that maybe the curtain was soiled and needed to be washed. This surveyor verbalized that observations were made on at least two different occasions and no staff member knew the reason for not having a privacy curtain. No other information concerning the above information was presented prior to exit conference on 12/15/16.	F 460		
F 465 SS=D	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.	F 465	**F 465** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** No Residents, staff or visitor were found to have been affected. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents, staff or visitors who use the identified front handicap entrance ramps had the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Caution Signage was placed at each ramp which reads "Caution watch your step" on 12/21/16. Transition from pavement to sidewalk was painted to improve visibility of elevation change on 12/21/16. The facility has contacted outside vendor on 12/22/16 to have the identified ramps repaired, resurfaced and replaced to provide a smooth transition to the sidewalk. The vendor upon onsite evaluation on 12/30/16 has indicated this is planned to be completed in March 2017 when asphalt will be available and can cure properly. Vendor did also indicate verbally that if we have days above freezing repairs, resurfacing and replacement could occur earlier than March 2017.	

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F 465	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to provide a safe and functional environment for residents, staff and the public. Two outside handicap ramps leading to the facilities front entrance were in ill repair. The Findings include: General observations were conducted on 12/14/16 at 10:30 a.m. at the front entrance to the facility. Observations were made of two handicap accessible ramps leading into the facilities main entrance were made up of asphalt and were uneven and sat one inch below the top of the sidewalk creating a trip hazard. On 12/14/16 at 11:00 a.m. the above finding was also observed by the maintenance staff (other staff, OS #2). OS #2 verbalized that the asphalt had been patched during the summer time and verbalized understanding that the ramps had bumps, uneven patching and did not have a smooth transition to the side walk creating a trip hazard. OS #2 verbalized that he would pass this information onto his supervisor and get the ramps fixed. On 12/14/16 at 11:30 a.m. during a meeting with the administrator and the director of nursing the above information was presented, the administrator or DON did not comment. No other information concerning the above information was presented prior to exit conference on 12/15/16.	F 465	**4.) The Facility will monitor its performance to make sure solutions are sustained.** The ramps will be audited weekly by Administrator and or maintenance department to ensure interventions are in place until ramps can be repaired, resurfaced and or replaced. Results of the audits will be submitted monthly to QAPI for 3 months or until ramps are repaired, resurfaced and or replaced. **5.) Date Corrective Action will be completed.** 01/04/17	

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F 502 SS=D	Continued From page 18 483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to obtain a physician ordered laboratory test for 1 of 21 residents (Resident #11.) Findings: Resident #11 was admitted to the facility on 12/3/10. His diagnoses included hypertension, depression, Bipolar disorder and chronic obstructive pulmonary disorder. The resident's latest MDS (minimum data set) assessment dated 11/1/16 coded the resident with slight cognitive impairment. He was coded as needing assistance to accomplish all ADLs (activities of daily living.) Resident #11's CCP (comprehensive care plan), updated on 12/1/16, included a focus for the "potential for drug-related complications associated with the use of psychotropic medications...." The interventions included, "Provide medications as ordered by physician and evaluate for effectiveness." Resident #11's physician's orders, signed and dated on 12/1/16, included orders for: 1. "Depakote Sprinkles Capsule. Give 500 mg by	F 502 F 502	**F 502** **1.) How the Corrective Action was accomplished for those residents found to have been affected.** Resident #11 lab was obtained on 12/15/16. **2.) How the facility will identify other residents having the potential to be affected by the deficient practice.** Residents with lab orders have the potential to be affected. **3.) The Following Measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** The Nurse Unit Managers will review lab orders for missing labs by 12/29/16. Lab orders and results will be reviewed in daily clinical standup meetings to ensure quality and timeliness, physician notification and follow up. Nurse Unit Manager will conduct monthly lab audits. **4.) The Facility will monitor its performance to make sure solutions are sustained.** Results of the lab audits will be reviewed for timeliness and quality and physician notification monthly. Results and findings of the audits will be reported in QAPI for 3 months for review and action steps. **5.) Date Corrective Action will be completed.** Compliance Date is 01/04/17	

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mouth two times a day related to Bipolar disorder."
2. "Depakote level Q (every) six months." (Initiated 10/24/13.)

The clinical record contained a laboratory result for a Depakote level drawn on 3/11/16. The record did not contain laboratory results for a Depakote level drawn in September 2016.

On 12/14/16 at 11:45 AM the administrator and director of nursing were informed of the surveyor's findings and asked about the missing lab work for the September 2016 Depakote level.

On 12/14/16 at 2:00 PM LPN I was interviewed by the surveyor. She said the resident had been scheduled for the Depakote level on 9/28/16, but the lab tech had not been able to obtain the sample. It was supposed to have been done by another lab tech the following day, but was overlooked.

LPN I said the physician had been notified and provided a new order to obtain the labwork on the next lab day (12/15/16.)

No additional info was provided prior to the survey team's exit.

OFFICE OF LICENSURE AND CERTIFICATION
VIRGINIA DEPARTMENT OF HEALTH

FACSIMILE TRANSMITTAL SHEET

TO: Mr. Hershel Sedoris, Administrator	FROM: Elizabeth Hudnall, LTC Supervisor
FACILITY: Alleghany Health & Rehab	DATE: 1/3/17
FAX NUMBER: (540) 862-4178	TOTAL NO. OF PAGES INCLUDING COVER: 1
PHONE NUMBER: (540) 862-5791	SENDER'S REFERENCE NUMBER: PHONE # (804) 367-2100
RE: NOTICE: Unacceptable Plan of Correction	CONTACT SUPERVISOR FOR QUESTIONS ABOUT NOTICE: Elizabeth Hudnall

☐ URGENT X FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

Your plan of correction (POC) for the survey ending 12/15/16 did not explicitly and consistently address each of the five required points within the context of the federal requirements. A MFI (medical facilities inspector) will be calling you.

O Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

O Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

☐ Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

O Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

O Include dates when the corrective action will be completed for Sate cross reference. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

9960 MAYLAND DRIVE
SUITE 401
RICHMOND, VIRGINIA 23233-1463